IDAHO DEPARTMENT OF
HEALTH & WELFARE

COPY

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

January 8, 2008

Jason Watts
Teton Home Health
3101 Valencia Drive
Idaho Falls, Idaho 83404

Dear Mr. Watts:

This is to advise you of the findings of the Medicare survey at Teton Home Health which was concluded on December 19, 2007.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **January 21, 2007**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208)334-6626.

Sincerely,

Sylvia Creswell for

RAE JEAN MCPHILLIPS
Health Facility Surveyor
Non-Long Term Care

Sylvia Creswell

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/mlw

Enclosures

TETON PHARMACY
I.V. HOME HEALTH & OXYGEN
The Leader of IV Home Care

January 11, 2008

Sylvia Creswell and Rae Jean McPhillips
Bureau of Facility Standards
P.O. Box 83720
Boise, ID 83720-0036

Dear Mss. Creswell and McPhillips:

Thank you for your letter dated Jan.8, 2008 advising us of the findings of the Medicare survey at our Home Health facility which concluded 12-19-2007. I would like to tell you how much I appreciated the surveyors who were here, Ms. McPhillips and Mr. Hendrickson. They were very helpful to us and used the survey as a tool for teaching us about compliance with state and federal guidelines. Their professionalism and interest in patient care was apparent at all times.

Attached you will find the Plan of Correction for the Statement of Deficiencies, listing all the required elements.

Thank you for your attention to this matter.

Feel free to call us if you have any questions. Please ask for Sheandi Richins, Assistant DON, if you call from 1-14 thru 1-18, as I will be out of town. I will be back in the office on 1-21.

Respectfully,

Shauna Smith

Shauna Smith, RN DON

3101 Valencia • Idaho Falls, ID 83404
Phone: (208) 529-3636 or 1 (800) 606-3637 • Fax: (208) 528-6562 or 1 (800) 708-6562

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137061	A. BUILDING _____ B. WING _____	12/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TETON HOME HEALTH	3101 VALENCIA DRIVE IDAHO FALLS, ID 83404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification of your agency. Surveyors conducting the review were: Rae Jean McPhillips, RN, HFS, Team Leader Patrick Hendrickson, RN, HFS Acronyms used in this report: CNA = Certified Nurse Aide DNS = Director of Nursing Services HHA = Home Health Agency POC = Plan of Care SOC = Start of Care	G 000	RECEIVED JAN 14 2008 FACILITY STANDARDS	
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on review of clinical records, agency policies, and interview, it was determined the HHA failed to ensure that nursing visits were provided as ordered on patients' POCs and that physicians were notified of the missed visits for 2 of 11 patients (#'s 7 and 9) whose records were reviewed. The agency's "General Administrative Policy-II.12", "CLINICAL RECORDS", revised on 5/4/07, stated "Missed visits will be documented on a 'Missed Visit' form." The policy did not include the agency's process of notifying the physician of the missed visits.	G 158	Policy II.12 has been revised (1-8-2008) to state "When patient visits are missed by any discipline, they will be documented on a "Missed Visit" form, explaining why the visit was missed. The attending physician will be notified of the missed visit either by phone call or by fax each time a visit is missed, unless it is when the visit was missed due to an appointment with the attending physician. Documentation of physician notification will be made in the space provided on the bottom of the Missed Visit form." Nursing Service will monitor compliance with this new policy by conducting a concurrent review of 50% of the charts on January 31, 2008, and again on February 29, 2008. If compliance is 100% on both dates, no further chart review will be conducted. If compliance is less than 100%, this review will continue monthly until 2 consecutive 100% compliance months are documented. All nursing staff have been educated regarding this Procedure.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shawna Smith RN	DON	1-11-08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 158	Continued From page 1 * Patient #7 was a 51 year old male with a SOC of 8/21/06. The patient's POC documented that Nursing was to visit 1 times a week for 9 weeks. The record contained 4 "Missed Home Health Visit" notes dated 11/1/07, 11/2/07, 11/26/07 and 11/30/07. There was no documented evidence that the physician had been notified of the missed visits. * Patient #9 was a pediatric patient with a SOC of 9/26/07. The patient's POC documented that Nursing was to visit 1 time a week for 9 weeks. The record contained 4 "Missed Home Health Visit" notes dated 11/5/07, 11/12/07, 11/19/07 and 11/26/07. There was no documented evidence that the physician had been notified of the missed visits. On 12/18/07 at 11:15 AM, the DNS stated it was not the agency's practice to notify physicians of missed visits. The Home Health Agency altered the POC when it provided fewer visits than ordered by the physician. Additionally, the HHA failed to notify physicians of the missed visits.	G 158		
G 224	484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was	G 224		

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G 224	Continued From page 2 determined the agency failed to ensure the registered nurse developed the aide care plan, which included visit frequency and duration, and parameters for vital signs to guide the aide in reporting abnormal vital signs to the registered nurse for 1 of 1 sampled patients who received home health aide services (#10). The findings include: * Patient #10 was a female patient with a SOC of 9/21/07. The record contained a physician's order, dated 10/15/07, for a CNA to assist the patient with bathing and the monitoring of vital signs. The record did not contain written patient care instructions developed by a RN for the home health aide. On 12/18/07 at 2:00 PM, the Director of Nursing stated prior to a CNA providing cares to a patient she gave them verbal instructions but she did not develop written care instructions for CNAs which outlined what cares the aide was to provide, visit frequency, or parameters for vital signs to guide the aide.	G 224	G224 A Care Plan for Nurses Aides is now available which includes visit frequency and duration, & provides for parameters for vital signs and instructions for the Aide which are individualized to the patient's needs. Use of this Aide Care Plan has been in effect since 12-27-2007. It is a three part form so that one copy is kept in the patient chart, one in the patient home, and one for the Aide. DNS or Assistant DNS will ensure the Care Plan is reviewed with the Aide at start of care and will co-sign with the Aide. All nursing staff have been educated regarding this Procedure.	
G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Based on review of clinical records, policies, and staff interview, it was determined the HHA failed to ensure that patient assessments, for 11 of 11 records whose records were reviewed (#s 1-11),	G 337		

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G 337	Continued From page 3 included a review of all medications patients were currently receiving to identify any potential adverse effects or drug reactions. The findings include: 1. The agency's "General Administrative Police-II.32", "PATIENT OWNED MEDICATIONS IN THE HOME", revised on 8/20/06, stated "All current patient medications shall be documented on admission....Skilled Nursing with [sic] identify any potential adverse effects or interactions and clarify them with the patient's physician." The policy did not include how nursing staff were to document the review of patients' medications to identify any potential adverse effects, drug reactions, ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. 2. The clinical records for Patients #s 1-11 were reviewed. All records listed medications patients were taking. However, none of the records contained documentation of a review of those medications in order to identify any potential adverse effects, drug reactions, ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. The DNS interviewed on 12/18/07 at 2:40 PM, confirmed that patient records did not contain documented evidence that nurses reviewed patients' medications to identify any potential adverse effects, drug reactions, ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.	G 337	G337 Documentation was added to all patient assessment forms indicating that the medications have been reviewed by the Skilled Nurse for potential adverse effects, reactions, interactions, duplications and patient non compliance. This was added in the form of a printed sticker which states: "Medication regimen reviewed for possible adverse effects, interactions, duplicates & significant side effects," and has a signature space for the SN. Policy #II.32 has been expanded and revised to describe the above procedure. Documentation of follow-up with physicians regarding problems identified with the medications will be recorded on a "Care Coordinator" note and made a part of the permanent Medical Record. DNS will monitor all charts to ensure compliance for the month of January, 2008. Chart monitoring will continue until 100% compliance is achieved. All nursing staff have been educated regarding this Procedure.	

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N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the State recertification of your agency. Surveyors conducting the review were: Rae Jean McPhillips, RN, HFS, Team Leader Patrick Hendrickson, RN, HFS	N 000	RECEIVED JAN 14 2008 FACILITY STANDARDS	
N 044	03.07021. ADMINISTRATOR N044 021. ADMINISTRATOR. An administrator shall be appointed by the governing body and shall be responsible and accountable for implementing the policies and programs approved by the governing body. This Rule is not met as evidenced by: Refer to Federal deficiency G 158, as it relates to the failure of the administrator to ensure the agency's policies were followed and home visits were provided as ordered on the plan of care.	N 044	N 044 Policy II.12 has been revised (1-8-2008) to state "When patient visits are missed by any discipline, they will be documented on a "Missed Visit" form, explaining why the visit was missed. The attending physician will be notified of the missed visit either by phone call or by fax each time a visit is missed, unless it is when the visit was missed due to an appointment with the attending physician. Documentation of physician notification will be made in the space provided on the bottom of the Missed Visit form." Nursing Service will monitor compliance with this new policy by conducting a concurrent review of 50% of the charts on January 31, 2008, and again on February 29, 2008. If compliance is 100% on both dates, no further chart review will be conducted. If compliance is less than 100%, this review will continue monthly until 2 consecutive 100% compliance months are documented. All nursing staff have been educated regarding this Procedure.	
N 122	03.07024.SK.NSG.SERV. N122 05. Training, Assignment and Instruction of A Home Health Aide. c. Written instructions for home care, including specific exercises, are prepared by a registered nurse or therapist as appropriate. This Rule is not met as evidenced by: Refer to Federal deficiency G 224, as it relates to the failure of the agency to ensure the registered nurse completed the aide care plan, included the	N 122	N 122 A Care Plan for Nurses Aides is now available which includes visit frequency and duration, & provides for parameters for vital signs and instructions for the Aide which are individualized to the patient's needs. Use of this Aide Care Plan has been in effect since 12-17-2007. It is a three part form so that one copy is kept in the patient chart, one in the patient home, and one for the Aide. DNS or Assistant DNS will ensure the Care Plan is reviewed with the Aide at start of care and will co-sign with the Aide. All nursing staff have been educated regarding this Procedure.	

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N 122	Continued From page 1 visit frequency and duration, and vital sign parameters to guide the aide in reporting abnormal vital signs to the registered nurse.	N 122		
N 173	03.07030.07.PLAN OF CARE N173 07. Drugs and Treatments. Drugs and treatments are administered by agency staff only as ordered by the physician. The nurse or therapist immediately records and signs oral orders and obtains the physician's countersignature. Agency staff check all medications a patient may be taking to identify possible ineffective side effects, the need for laboratory monitoring of drug levels, drug allergies, and contraindicated medication and promptly report any problems to the physician. This Rule is not met as evidenced by: Refer to Federal deficiency G 337, as it relates to the failure of the agency to ensure medications were reviewed to identify any potential adverse effects, drug reactions, ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, or noncompliance with drug therapy.	N 173	N 173 Documentation was added to all patient assessment forms indicating that the medications have been reviewed by the Skilled Nurse for potential adverse effects, reactions, interactions, duplications and patient non compliance. This was added in the form of a printed sticker which states: "Medication regimen reviewed for possible adverse effects, interactions, duplicates & significant side effects," and has a signature space for the SN. Policy #II.32 has been expanded and revised to describe the above procedure. Documentation of follow-up with physicians regarding problems identified with the medications will be recorded on a "Care Coordinator" note and made a part of the permanent Medical Record. DNS will monitor all charts to ensure compliance for the month of January, 2008. Chart monitoring will continue until 100% compliance is achieved. All nursing staff have been educated regarding this Procedure.	